



HOURLY ASSOCIATE ELECTION FORM PLAN YEAR 2020

 Open Enrollment

Dept: _____

Effective Date: _____

ASSOCIATE INFORMATION (Please Print)

Date of Hire _____

First Name _____

Last Name _____

M / F _____

Date of Birth _____

Address _____

City _____

State _____

Zip Code _____

 Single Married Divorced

Social Security # _____

Telephone Number: _____

DEPENDENT INFORMATION

	Med ✓	Den ✓	Vis ✓	First Name	Last Name	Social Security #	Sex	Date of Birth	Student
SELF									
<input type="checkbox"/> Add									
<input type="checkbox"/> Delete									
SPOUSE									
<input type="checkbox"/> Add									
<input type="checkbox"/> Delete									
CHILD									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add									
<input type="checkbox"/> Delete									
CHILD									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add									
<input type="checkbox"/> Delete									
CHILD									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add									
<input type="checkbox"/> Delete									

* If enrolling more than three children, please attach a separate sheet.

ALL AMOUNTS ARE SHOWN ON A WEEKLY BASIS
MEDICAL PLANS

Please check one.

	Associate Only	Associate & Spouse	Associate & Child(ren)	Associate & Family
Blue Secure PPO - BCBS	<input type="checkbox"/> \$52.00	<input type="checkbox"/> \$111.25	<input type="checkbox"/> \$101.50	<input type="checkbox"/> \$133.50
MVP PPO - BCBS	<input type="checkbox"/> \$21.50	<input type="checkbox"/> \$50.00	<input type="checkbox"/> \$47.50	<input type="checkbox"/> \$56.50
Health & Savings PPO - BCBS	<input type="checkbox"/> \$27.25	<input type="checkbox"/> \$60.50	<input type="checkbox"/> \$57.50	<input type="checkbox"/> \$68.25
<input type="checkbox"/> DECLINE COVERAGE				

DENTAL PLAN

Please check one of the dental plan options listed below.

	Associate Only	Associate & Spouse	Associate & Child(ren)	Associate & Family
Indemnity - Delta Dental	<input type="checkbox"/> \$2.75	<input type="checkbox"/> \$5.25	<input type="checkbox"/> \$5.50	<input type="checkbox"/> \$6.00
<input type="checkbox"/> DECLINE COVERAGE				

VISION PLAN

Please check one of the vision plan options listed below.

	Associate Only	Associate & One	Associate & Family
Vision Plan - EyeMed	<input type="checkbox"/> \$1.15	<input type="checkbox"/> \$2.19	<input type="checkbox"/> \$3.20
<input type="checkbox"/> DECLINE COVERAGE			

SIGNATURE

I wish to make the choices indicated on this form and authorize The Dixie Group to make any necessary pre-tax deductions for the plan year. I understand that pre-tax contributions will slightly impact my social security contributions. By signing below I certify that the information on this form is complete and accurate and that I have read and understand the fraud warning. If for any reason I fail to complete a new enrollment form each plan year, the elections shown on this form for my medical, dental, and vision coverage will remain unchanged, although the cost may change. If changes occur during the year that affect this information, I will notify Human Resources within 31 days of the change. I understand that a copy of this form will be made available at my request.

Signature _____

Date _____